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Express Scripts Provider Certification
Application Type: PSAO Credential

GENERAL INFORMATION: Date Submitted: 03/04/2014

Check one: ☐ New Pharmacy Application — Date Pharmacy opened:

☐ Change of Ownership Application — Date ownership effective:

☒ Existing Pharmacy Application

Are you affiliated with a PSAO? ☒ Yes ☐ No — Name of PSAO: TrueCare; 540

Are you affiliated with a GPO? ☐ Yes ☒ No — Name of GPO:

NCPDP: 5900952 — NPI: 1518274281

CHAIN CODE: — FEDERAL TAX ID: 800588406 (If applicable)

Pharmacy Name: Alternative Medicine and Pharm

Legal Name: Alternative Medicine and Pharmacy, Inc.

Address: 4401 Dowling Street — City: Houston — State: TX — Zip: 77004-9932

County: Harris — How long has pharmacy been at this address? 3 Years, 10 Months

Phone Number: 7138740300 — Fax Number 7138740314

Mailing Address *(If different from Physical Address above)*

Address: 4916 Main Street, Suite 100 — City: Houston — State: TX — Zip: 77002

Remittance Address

(If different from Mailing Address above) — Name to be printed on check: Alternative Medicine and Pharmacy, Inc.

Address: 4916 Main Street, Suite 100 — City: Houston — State: TX — Zip: 77002

Contact Person: Branko Milosevic

Pharmacy Permit Number: 27016

OWNERSHIP / AUTHORIZED INDIVIDUALS:
Total # of Owners: 1

Owner First Name	*Middle Initial*	*Owner Last Name*	*Percent of Ownership*	*Owner Email Address*
Alternative Medicine		and Pharmacy, Inc.	100.00	branko@omniplushealthcare.com

GOVERNMENT EXHIBIT 212 4:18-CR-368

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Other individuals authorized to sign on owner's behalf:

First Name	*Last Name*	*Email Address*
Branko	Milosevic	branko@omniplushealthcare.com

List names and license #s of all Pharmacy Applicant's Pharmacists and Pharmacy Techs

Pharmacist/Prescriber in Charge:	Raghuveer Chintalapally	License #	45965
Pharmacist Name:	Hemlata Kataria	License #	52562
Pharmacist Name:	Amy Adams McNeely	License #	28304
Pharmacist Name:	Lynh Phan	License #	33090
Pharmacist Name:	Jaimson Abraham	License #	52468
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharmacist Name:		License #	

TYPE OF PRACTICE: Indicate the anticipated percentage of Rx volume in each setting

☒	Open Door Retail/ Community	98.00	%					☒	Medicaid	6.00	%
☐	Closed Door/ Clinic Facility		%					☒	Medicare	10.00	%
☒	Mail Order	2.00	%	☐	Local	☒	Out of State 100.00%	☒	Workers Comp	3.00	%
☐	Nursing Home/ LTC		%					☐	340B		%
☐	Internet Pharmacy		%	☐	New	☐	Refills %	☒	Compounds	5.00	%
☐	Home Infusion		%						Ship to other states? Yes Louisiana and Oklahoma		
☐	Self Administered Injectable/Specialty		%								
☐	Other		%					☐	Dispensing Physician		%
	List Other:										

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BUSINESS INFORMATION:

Federal DEA #: FA2175708 State Tax ID: 32041738959 State: TX

Medicaid #: 146241 State: TX Insurance Carrier: Sentinel Ins Co LTD

If more than one state attach list:

Software Vendor: PioneerRx Switch Company: Emdeon

Pharmacy Website URL:

Hours of Operation:

M-F 8:00 AM 5:00 PM Sat: 8:00 AM 12:00 PM Sun: _____ AM _____ PM

☐ Open 24 hrs

☒ E-Prescribing / Vendor: PioneerRx ☐ Braille Labeling ☐ Emergency Services ☒ Handicap Access

☐ Drive-Through ☐ TTY (Hearing Impaired) ☒ Delivery Service/Mileage 50 miles ☒ Out of State

	QUESTIONNAIRE SECTION	YES	NO
1	**Are three (3) or more pharmacies covered by this application assigned the same NCPDP chain code?** *If yes, please list the NCPDP numbers and the applicable chain code:*	☐	☒
2	**Is this pharmacy an open-door pharmacy that fills prescriptions for all walk-in customers without restrictions?** *If no, please provide detailed explanation of pharmacy restrictions:*	☒	☐
3	**Do you maintain electronic patient profiles?**	☒	☐
4	**Do you review prescriptions dispensed for drug interactions?**	☒	☐
5	**Is the pharmacy equipped to submit claims electronically in the most current NCPDP format?**	☒	☐
6	**Are you currently affiliated with a buying group or co-op other than a PSAO (e.g., GPO)?** *If yes, please list the name of affiliated buying group:* American Pharmacies	☒	☐
7	**Has the pharmacy previously participated in an Express Scripts or Medco pharmacy network?** *If yes, when and under what name(s) and NCPDP number(s)?* 08/01/2010 - Alternative Medicine and Pharmacy - 5900952	☒	☐
8	**Do you provide any special services or have distribution rights to any specialty medications?** *If yes, please provide a detailed description of services or specialty medications supplied:*	☐	☒

9	Has the pharmacy (or another pharmacy you have owned) been disciplined by a State Board of Pharmacy, government entity or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department)? *If yes, please provide explanation of action taken, board order letter, and any other supporting documents from the State Board of Pharmacy, government entity, or other regulatory authority.*	☐	☒
10	Have any of the pharmacists, pharmacy technicians, owner or employee(s) of the pharmacy been disciplined by the State Board of Pharmacy, a government entity, or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department) in the last 10 years? *If yes, please provide details and attach letter(s) of disciplinary action.*	☐	☒
11	Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s) or any of its pharmacists been the subject of a civil lawsuit or criminal prosecution involving fraud, deceit, deception or a similar offense involving moral turpitude? *If yes, please provide detailed explanation:*	☐	☒
12	In the last 10 years, has the pharmacy or any of its owners/principals filed for bankruptcy, reorganization, or made a general assignment in favor of creditors? *If yes, please provide detailed explanation.*	☐	☒
13	Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s), its pharmacists, or any of its employees been suspended or excluded by the Office of Inspector General (OIG) from participating in any federal or state health care program (e.g., Medicare, Medicaid, TRICARE) or by the General Services Administration (GSA) from participating in any government contract/services? *If yes, please provide detailed explanation including applicable dates:*	☐	☒
14	Have any of the owner(s), member(s)/principals(s), officers, or directors of the Pharmacy owned any other Pharmacy(ies)? *If yes, please provide a list of the pharmacies, their NCPDP number(s), and the names of the owners, entity member(s)/principal(s), officers and directors:* Omniplus Health Care, LP - 4597994 - Brian Swiencinski, Vladimir Redko and Dejan Milosevic	☒	☐
15	Has the pharmacy ever changed names? *If yes, please provide a list of the previous name(s), NCPDP number(s) if different, and the date(s) the name changed:*	☐	☒

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16	Has the pharmacy ever undergone a change in ownership? *If yes, please provide a list of the previous owner's name(s), ownership dates, and NCPDP number(s) if different:*	☐	☒
17	Is the pharmacy a Medicare Part B Provider? *If yes, please provide the Pharmacy's Part B Provider Number:*	☐	☒
18	In the past three (3) years, has any vendor providing services, supplies or medications to this Pharmacy, been excluded from participation in Federal or state health care program or government contract, or been otherwise subject to any restriction by the OIG or other state or government agency? *If yes, please provide detailed explanation including applicable dates.*	☐	☒
19	Does the pharmacy have a separate designated area for patient consultation?	☒	☐
20	Has the pharmacy obtained any accreditations/certifications (e.g., PCAB, ACHC, The Joint Commission, URAC, VIPPS, etc.)? *If so, please submit a copy of certification(s).*	☐	☒
21	Does the owner/pharmacist-in-charge currently hold any non-resident state licensure(s)? *If yes, please submit a copy of license(s).*	☒	☐
22	Does the pharmacy provide sterile compounding medications? *If yes please provide most current certification document* (e.g., PCAB, air flow hood/HEPA filtration, etc.).	☐	☒
23	Are you HIPAA or Hi-Tech Compliant?	☒	☐
24	Do you or your pharmacy(ies) deliver prescriptions to out-of-state customers? *If Yes, identify states where you plan to service customers and provide corresponding out-of-state pharmacy licenses:* LA - PHY.006763-OS; MN - 264281	☒	☐
25	Do you or your pharmacy(ies) contract with or employ a sales force? *If Yes, please describe the activities of the sales force:*	☐	☒
26	Do you or your pharmacy(ies) provide compound product samples to prescribers or members? *If Yes, please describe when/how samples are provided:*	☐	☒
27	Do you or your pharmacy(ies) provide compounding services for or through any other entities (i.e. providing compounds services through other pharmacies or directly to prescribers for dispensing)?	☐	☒
28	Do you or your pharmacy(ies) compound investigational/Non-FDA approved compounds (i.e. Domperidone, Estriol, and Cetyl Mesylfloate Oil)? *If Yes, please provide all Investigational New Drug Applications (INDs)*	☐	☒
29	Do you or your pharmacy(ies) ever waive or offer a reduction of member copayments? *If Yes, please provide a copy of your written policy relating to the waiver/reduction of copayments.*	☐	☒
30	Do you or your pharmacy(ies) use or provide pre-printed prescription forms for any of your compound preparations? *If Yes, please provide examples of any prescription forms*	☒	☐

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31	**Does any person with prescriptive authority have a direct or indirect financial interest in the pharmacy(ies)? For the purposes of this question, a "financial interest" includes, but is not limited to, any direct ownership, ownership by an immediate family member (spouse, child, etc.), paid consulting relationship, waged or salaried employment relationship?** ***If Yes, identify the individual and describe his or her financial interest:*** Vladimir Redko, MD (has 40% ownership interest in the pharmacy)	☒	☐
32	**Identify the names of all primary and secondary wholesalers/suppliers that service your pharmacy(ies). Provide a copy of the most recent invoices from each wholesaler/supplier** AmerisourceBergen, PBA Health		
33	**Do you have a policy in place for setting your usual and customary price?** ***If Yes, please provide a copy***	☐	☒
34	**Do you have a central fill or shared services arrangement with any other pharmacy or facility?** ***If Yes, please provide the corresponding licenses and identify all pharmacies/facilities with which you have such a relationship:***	☐	☒

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Indicate all languages other than English spoken by staff within this pharmacy and languages in which prescription drug labels can be provided:

Lang	Label		Lang	Label		Lang	Label		Lang	Label	
☐	☐	Arabic	☐	☐	Armenian	☐	☐	Cambodian	☐	☐	Chinese
☐	☐	Farsi	☐	☐	French	☒	☐	Hindi	☐	☐	Indian
☐	☐	Japanese	☐	☐	Korean	☐	☐	Mandarin Chinese	☐	☐	Russian
☒	☐	Spanish	☐	☐	Tagalog	☒	☐	Vietnamese	☐	☐	
☒	☐	Other	Serbo-Croatian								

- I certify that each answer on this Provider Certification (including attachments) is true and correct.
- I agree to notify Express Scripts immediately in writing in the event of a change in the information provided which would make any part of this Provider Application untrue or inaccurate. I understand that failure to do so will be considered a breach of my Provider Agreement and could result in disciplinary action including, but not limited to, immediate termination of my Provider Agreement.
- I give Express Scripts, and its designee(s), if any, permission to contact any individual, company, organization, etc, including state and federal licensing agencies, as may be necessary to verify the information submitted herein and to ask questions about disciplinary action, the pharmacy's license, or any pharmacist licensed, employed by or dispensing prescriptions at the pharmacy.

Printed Name: Branko Milosevic

Signature: Branko Milosevic

Title: Authorized Signatory

Date: 03/04/2014